Lessons From the Practice

Hypoglycemia in Bosnia

ROD HAMER, MD, *Santa Barbara, California*

During a recent overseas assignment, a general rule of medicine was reaffirmed for me: do not accept another physician's diagnosis at face value. As a volunteer to aid in the training of young physicians and nurses in an emergency department (ER) in central war-torn Bosnia, I had arrived just before 0800 for my first day. An interpreter introduced me to Dr Asim, a bright and "take-charge" resident. We toured the department, and I was pleased that he could communicate in halting English.

At the time, there was only one patient in the ER, an older man in his 60s. He lay passively on a gurney while an aged monitor's beep verified his being alive. "What is wrong with him?" I asked Dr Asim.

"Have 'strock,'" he replied.

"What will you do for his stroke?"

"Admit Neuropsychiatric Unit. He die," was the reply.

At the time, I was unaware that after a lengthy wait in the ER, the patient would be taken to the neuropsychiatric receiving room. There he would again wait for an admitting physician to do another assessment, delaying any treatment another four or more hours, if there were any treatment.

The ER tour finished, I had my first kava (coffee) break, which was a social event of high priority and frequency. A dozen or more physicians and nurses from several departments sat on beds and chairs, smoking, chatting, and sipping the silt-like Turkish coffee. The "strock" victim lay unattended in another room with no intravenous line, no oxygen, and no restraints to prevent his falling to the floor. As far as I could tell, they had "seen" him, made a disposition, and their attention to him had ended.

Driven off by secondhand smoke, I wandered back to the patient's bedside and, out of curiosity, examined him. There were some findings that seemed to negate Dr Asim's diagnosis. There was no facial droop, no limb weakness, and bilateral Babinski's were present. He was awake, and his eyes slowly followed me. I wondered about a more global neurologic problem such as a metabolic encephalopathy.

Dr Asim returned from the coffee festival and silently watched me. Was he upset about my snooping? Had I, having been there only half an hour, already offended him? I nonchalantly asked if a blood sugar determination was available. I was surprised when he said, "Sure," and then astonished when he said, "Take four hours."

I suggested we draw a blood specimen and send it off and then gambled with my chance of having my hunch validated. At my urging, a nurse administered 25 ml of a 50% dextrose solution. The response was dramatic. Like spinach to Popeye, the D50W bolus awakened the patient's hypoglycemic brain, and a few minutes later, he was asking for kava and a cigarette.

When the dramatic change in the patient occurred, the Bosnians gave me a round of applause and high-fives. Two younger men appeared at the bedside, amazed that their father was alive and greeting them. They had brought him to the ER, were told that he was dying, and they had gone to order a coffin, a commodity in great demand in Bosnia. The brothers confirmed the patient's previous diagnosis of diabetes and that the father self-injected a medicine each morning. Unaware of its relevance, they had not told the staff nor were they asked. Soon "Poppa" went home with them, his "strock" having resolved.

* * *

"Lessons From the Practice" presents a personal experience of practicing physicians, residents, and medical students that made a lasting impression on the author. These pieces will speak to the art of medicine and to the primary goals of medical practice—to heal and to care for others. Physicians interested in contributing to the series are encouraged to submit their "lessons" to the series' editors.

JONATHAN E. RODNICK, MD
STEPHEN J. McPHEE, MD
Assistant Editors

(Hamer R: Hypoglycemia in Bosnia. West J Med 1996; 165:399)

From the Student Health Service, University of California, Santa Barbara.
Reprint requests to Robert Hamer, MD, 1114 Bel Air Dr, Santa Barbara, CA 93106.